

Dental Insurance Enrollment/Change Form



EMPLOYEE BENEFITS

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor: North Dakota Public Employees Retirement System	Group/Plan: GH-28275-8	Agency/Department Name:	Agency/Department Number:
This change is due to: Initial Eligibility Following Hire Annual Enrollment Late Entrant due to Change in Family Status* Change Agency from _____ to _____			Effective Date of Coverage or Change: Address Change Add Dependent Delete Dependent Cancel Coverage Loss of Other Coverage Termination Retirement

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

Employee Name (<i>last, first, middle initial</i>)	Female Male	Date of Birth	Social Security #
Employee Address (<i>street address, city, state, zip code</i>)	Single Divorced Legally Separated	Married Widowed	Telephone Work Home

Elect or Decline Coverage

Elect Dental Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Waive Dental Coverage	IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION. I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for: (check all that apply) myself spouse only child(ren) only myself and entire family Should I desire to apply for Dental Insurance coverage in the future, I realize that a late entrant penalty may apply.			

Dependent Information *Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.*

Dependent Name (<i>last, first, middle initial</i>)	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.

** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

Other Dental Coverage Information *Complete if you and/or any dependent have dental coverage with another insurer or carrier.*

Employee/Dependent Name (<i>last, first, middle initial</i>)	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				Single Family
				Single Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ↓

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.

Employee's Signature	Date Signed
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